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ABSTRACT

"Learning 100" was used to assist chronic institutionalized mental patients in acquiring or recovering the skills needed for maintaining social interactions on the ward, listening to and comprehending radio and television broadcasts, reading newspapers--including classified advertisements, writing letters on personal business, and performing the necessary reading skills to hold an unskilled position. "Learning 100" was selected with the hopes of: (1) maintaining patients' attention, (2) providing a highly systematic, repetitive mode of presentation, (3) permitting a wide use of supplemental materials and small-group and teacher-directed activities, and (4) providing a system capable of instructing part of the time with little supervision by a certified teacher. The first report in this booklet contains the project proposal; the second report describes methods, procedures, and results of the study for the 46 patients involved; a word picture of some of the dramatic changes in behavior among the patients, indicating in some detail that the goals of the research project are in large part being met, is presented in the third report; and the fourth report discusses the use and growth of the psychiatric aides as managers of an individualized instructional program. (MF)

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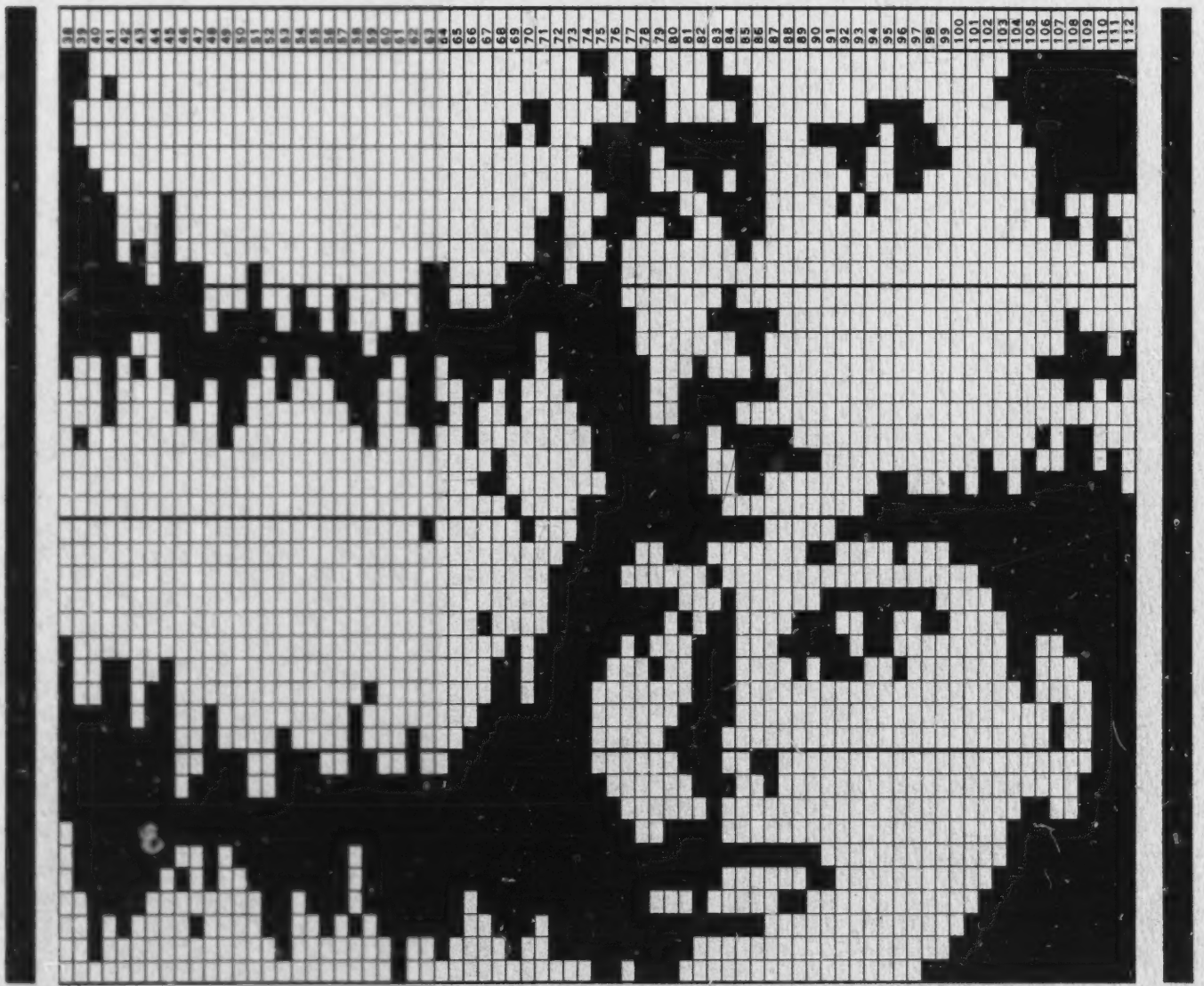

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Research and Information Report No. 6
EDL Research Department, July 1972

A Series of Research Reports on the Use of LEARNING 100 at Harrisburg State Hospital September 1970–September 1971

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FOREWORD

Why should one suggest that EDL/McGraw-Hill's material such as Learning 100 might be valuable to institutionalized mental patients who were unable to participate in the regular educational program of the hospital? As a former educational researcher with a special interest in human motivation and learning, it seemed to me worthwhile to try one or more systems of instruction in which hardware was an important factor in initiating, improving, and maintaining behavior.

The particular problem in which we were interested was that of assisting chronic patients in acquiring or recovering the skills needed for maintaining social interactions on the ward, listening to and comprehending radio and television broadcasts, reading newspapers including classified advertisements, writing letters on personal business, and performing the necessary reading skills to hold an unskilled position. In a sense we asked ourselves how we could possibly give serious attention to programs and activities – "treatments and therapies" – designed to improve a patient's behavior and bring about release from the hospital to a sheltered environment unless that patient had adequate verbal skills to cope with his world – ward, sheltered living, or home. Further, we wondered how many chronics might receive more attention – more "treatment and therapy" – if they were able to demonstrate some verbal skills akin to those of "normals."

Armed with these questions and a healthy skepticism of the value of traditional modes of instruction when used with adults, hospitalized adults at that, the writer asked EDL/McGraw-Hill to join with us in a pilot test of the notion that its materials and equipment might succeed with at least a few patients for whom there appeared to be little prospect of further education. The results are mixed, suggestive, fascinating in many regards, and filled with a few surprises. Not only were changes in reading, language usage, and other verbal behavior effected for some, but significant effects on the social adjustments and general well-being occurred.

The pilot work was well worth our time. We learned, patients learned, the staff changed some attitudes and became better teachers, and EDL/McGraw-Hill learned more of the versatility of its equipment and materials.

Wendell I. Smith, Ph.D.
Provost, Bucknell University

INTRODUCTION

In January of 1970, a meeting was held with Dr. Wendell Smith at Bucknell University. His ideas regarding a pilot research project were discussed and further elaborated upon. EDL/McGraw-Hill was particularly interested in this project since no formal study had been conducted previously on Learning 100 with a population of this kind – namely, chronic patients in a state hospital.

The Learning 100 System was described to Dr. Smith who mentioned that he felt it would be highly motivational for emotionally disturbed patients and would lend itself to behavior modification or operant conditioning studies.

Dr. David Lasky, Research Director, Harrisburg State Hospital, was contacted by Dr. Smith to see if he would be interested in such a research project. After the Harrisburg State Hospital staff had reviewed the literature on Learning 100 and compared their own goals to those of Learning 100, they indicated that they were quite enthusiastic about its applicability to a hospital environment. Dr. Lasky submitted a report to the EDL/McGraw-Hill Research Department, summarizing the results of the correlation between the hospital goals and those of Learning 100. His report stated:

The characteristics of the educable patient population at Harrisburg State Hospital suggest that a program of individualized instruction be developed. Learning 100 appears to be a reasonable program upon which to base individualized instruction for these reasons:

1. Emotionally disturbed patients tend to be inattentive, and the mode of presentation used in Learning 100 will help in maintaining attention to the material.

2. Adults with a long record of chronic failure in school and at work will need a highly systematic, repetitive mode of presentation as the basic approach.

3. Learning 100 will permit wide use of supplemental materials and modes of instruction which, it is suspected, will be necessary if acquisition, retention, and transfer of training are to be maximized. The provision for small-group and teacher-directed activities is an

important quality for a system to possess for these patients.

4. The program which is used must be clearly broken into objectives, concepts, and levels so that patients can be given diagnostic tests and started with appropriate concepts on appropriate levels. Learning 100's cycles of sequenced instruction fit these requirements. As noted in the guide, "The carefully structured program of skill development places success within reach of students who have a history of repeated failure, and whose socioeconomic background has rendered them unable to cope with traditional curricula."

5. Since educational training of patients usually will occur in a context of vocational rehabilitation, the materials used for education should support, never conflict with, vocational training.

6. Many patients will have to engage in learning in the ward rather than in the classroom. Further, they often will have to work under the direction of charge nurses and psychiatric aides; hence, the system used must be capable of instructing part of the time with little supervision by a certified teacher. The Learning 100 System appears capable of meeting this rather unique requirement.

7. Considerable adaptation of the program which is to be used seemingly will be necessary to meet the conditions for educating emotionally disturbed adults. One form which this will take is contingency management techniques in which the reinforcements will be as varied as the staff learns to make them, e. g., working for rewards ranging from access to preferred materials and equipment to escape from non-preferred tasks.

While state mental hospitals are decreasing their census, they are simultaneously increasing the proportion of patients who lack basic educational skills. At Harrisburg State Hospital, approximately 800 of the 1600 resident patients have eight years of schooling or less. The number of patients functioning below this level is even greater.

Our education program is now serving 125 patients. The pressure of numbers in the classroom is such that the program is carried out by rather traditional methods. Little attention has been given to the functionally illiterate, although these people are being returned from the hospital to the community in increasing numbers.

Since operant conditioning has been demonstrated to be highly effective in reinstituting social behavior in psychiatric patients, we would like to try the EDL Learning 100 program to determine its value to psychiatric patients in need of basic educational skills. Knowledge of results, immediate feedback, control of reinforcement contingencies, self-paced learning, and a stepwise progression in difficulty of tasks are factors which operant conditioning studies and the EDL Learning 100 program have in common. Therefore, we anticipate that EDL Learning 100 would be most valuable when applied to a basic education program for our patients.

Based on these initial contacts and on general agreement on the goals for the research project, a university psychology department, a state hospital, and a commercial publisher's research department decided to engage in a cooperative research venture.

A pilot project was begun in June of 1970, using Learning 100 with thirty patients in three ten-patient classroom groups. This period can best be described as a shakedown phase. Ensuring the availability of material appropriate for the various levels of students, providing in-service

training for the instructors, and providing the instructors with hands-on experience with the materials and audio-visual instruments utilized in Learning 100 characterized this period. In September of 1970, the research study officially began and extended over a period of one year.

The reports which follow were prepared by members of the Harrisburg State Hospital Research Department under the direction of Dr. David Lasky, with the assistance of Dr. Wendell Smith, Bucknell University, and the Research Director of Educational Developmental Laboratories, a Division of McGraw-Hill Book Company, both of whom acted as consultants for this research project.

The first report is a proposal for the therapeutic and educational programs which would be the treatment utilized in this project. This proposal was prepared by one of the psychiatric aides involved in the project.

The second report describes methods, procedures, and results of the study. A total of forty-six patients was involved in the educational program during the year and, in total, received 4,213 hours of Learning 100 instruction in 471 class periods.

The third report presents a word picture of some of the dramatic changes in behavior among the patients using the Learning 100 System. These case studies indicate in some detail that the goals of the research project are being met, if not in total, certainly in large part.

The fourth report discusses the use of the psychiatric aide as a manager of an individualized instructional program. In the research study described in this publication, the instructors, or program managers as they are called, are not certified teachers nor have they had any teaching experience prior to instructing the Harrisburg patients. If one had to point to one singular instance of success in this project, it would be the tremendous growth of the psychiatric aide as an effective manager of the Learning 100 instructional program.

Donald R. Senter, Ed.D.
Research Director

Educational Developmental Laboratories
A Division of McGraw-Hill Book Company
New York, N.Y.

Proposed EDL/McGraw-Hill Therapeutic and Educational Programs

Alan Buchanan

Need for an Educational Program

Harrisburg State Hospital, in its attempt to meet the educational needs of its clients, falls short of a productive program in the York-Adams Unit. There seems to be no adequate structure within the unit to meet basic education needs or skills. It is felt by staff in Y-8 that the opportunity for education should not be limited to particular groups whose behavior or ability merits their acceptance into a formal learning situation. Moreover, it is felt that the opportunity to learn basic skills needs to be offered to all those patients who demonstrate a potential to benefit from a classroom or learning environment.

In the case of retarded, regressed, or chronic problem patients, academic achievement may be limited. It has been observed many times that these individuals do not function within formal classroom environments. The reasons may vary from a lack of assumed responsibility to attend classes, short attention span, and pronounced psychotic behavior, to fear of stressful social competition or socialization in groups.

While there are special education programs within the hospital, the professionals cannot meet the needs of these patients simply because there are not enough professionals to go around. If enough professional teachers were hired as hospital employees, special programs could be initiated. Professional shortages are not uncommon—especially in the areas of mental health and retardation. The trend expressly is to make do with what you have. Harrisburg State Hospital unsurprisingly falls into this category in relation to education. We do not have available the professional teachers or therapists necessary to meet the demand of the institutionalized population.

Roles of Nonprofessional in Meeting Remedial Needs for Education

In September 1970, an EDL project was started which involved three (3) ward areas in the York-Adams Unit. An agreement was made between the Research Departments of Harrisburg State Hospital and Educational Developmental Laboratories (a Division of McGraw-Hill Book Company) for the use of the L-100 program, which was designed for adult education, to improve or teach basic communication skills. The basic issue to be tested was: Can this program be effective in this type of environment, utilizing nonprofessionals as substitutes for professional teachers? It is not my intention to go into detail concerning the experiment, but rather to give you an inside viewpoint of the program as conducted by a nonprofessional.

It has been said many times that the psychiatric aide has more knowledge of the individual needs of patients than a member of any other discipline. This is true simply because of the amount of time he spends with the patients. This time, if used productively, can lead to rapport which can influence behavior. The EDL program has to its advantage a rapport already established due to its setting on the ward. The program's first objective can be viewed as the reduction of the patient's anxiety in relating to unfamiliar people and surroundings. Simple but important, weeks of therapy are often required to establish relationships with clients. This

is only the first step in the slow process of total rehabilitation.

The EDL program, as an aid to rehabilitation, is believed to incorporate many motivational values that will benefit a total rehabilitation program:

a) Consistency. Class sessions are planned five (5) days a week – 20 days a month. Patients learn through constant encouragement to assume responsibilities to attend classes.

b) Personal Organization. Students learn to follow directions, assume good study habits, and make realistic decisions and choices.

c) Continuity of Thought. From the beginning basic communication skills to the more advanced levels, students learn to apply consistent thought processes to a particular subject.

d) Competition. Anxiety arising from competition with other patients is reduced. The patient is placed at his own level of capability and progresses at his own rate of speed.

e) Socialization. Patients learn to interact with teacher and group through supervised class discussions.

The preceding motivational values are not only necessary to continue education but to live in today's world. Academic achievement is the prime goal of the EDL program, but not its only benefit. The EDL program is a combination of academic striving and therapeutics directed toward behavior in order to attain that achievement.

L-100, as a program directed toward the minimizing of illiteracy, presents for adult education six (6) basic levels of achievement. The use of audio-visual, visual, and independent materials assists the aide in helping the student to interpret the material for himself. As many as four (4) different levels can be instructed in a single class period, allowing the student to progress slowly or rapidly according to his capability.

Problem

Another dynamic problem is that certain individuals cannot participate in the EDL program because of their behavior problems which include poor concentration spans, weak personal organization, and psychotic behavior. This requires too intensive supervision by the instructor since he is working with a group rather than with an individual. The purpose of the following outlined plan is to build up the patient to the level where he can work within a group. The problem of lack of socialization is most common with regressed and chronic patients, and requires much special attention.

In order to meet the need of therapeutic education programming, the following comprehensive plan is proposed:

I. Work With Patient on One-to-One Basis

A. Training of Aides

1. All interested psychiatric aides to be involved in the program are oriented to EDL techniques.

2. Each aide chooses two (2) patients in his group with whom to work.

3. Each aide works with his two patients on a one-to-one basis, using a specified L-100 entry level dependent upon each student's capabilities.

B. Use of Materials

1. EDL materials or other text materials equivalent to the level of the patient.

2. Incorporation of all forms of academic subjects such as personal hygiene, arithmetic, etc., into the program.

3. Magazines, newspapers, special interest articles, etc.

C. Evaluation Procedures

1. Use of academic goals to see whether the behavior problem and concentration span will improve enough to allow learning to take place.

2. Periodic evaluation of patient's progress by use of achievement tests.

3. Progress notes at the end of each instructional session.

II. Refer Patient to EDL

A. Procedure

1. Perceptual accuracy and visual efficiency:
   Use of Tach-X in order to build visual discrimination and memory.

2. Building experiences:
   Group-directed discussions to promote socialization and interaction.

3. Skill building:
   Use of Aud-X, Tach-X, Controlled Reader, Study Skills Library, and other related material to improve basic communication skills.

4. Application and enrichment:
   Follow-up activities of previously identified concepts in order to motivate application to environmental surroundings.

B. Goals

1. Prepare clients for further education, perhaps in formal setting.

2. Prepare those clients not capable of higher education for interaction and intercommunication in society.

Regressed patients could be prepared for further education by the use of L-100 and by employing a one-to-one ratio between aide and patient. It may work with psychotic patients, and seems worth the try. It is felt that the EDL program can increase the continuity of thought and lengthen the concentration span.

In conclusion, the main objective is to help underprivileged patients to increase their communication skills and, for those who are able, to obtain their high school diplomas.

The Educational Developmental Laboratories Program September 1970 - September 1971 Harrisburg State Hospital Technical Report No. 72-1

Betty R. Matter

In September 1971, the EDL/McGraw-Hill (Educational Developmental Laboratories) program was one year old. Since the experimental project began in the York-Adams Unit, 46 patients have had 4,213 hours of exposure to this unusual educational process. The three psychiatric aides who were trained to manage the program held 471 classes with the occasional help of several assistants. After a year of operation, assessment of the program indicates that it has a promising future, though some changes will be made.

A previous paper, "Educational Developmental Laboratories,"[1] described the research design of the project, but two points bear repeating. They are:

(1) A need for training in basic communication skills was identified for patients at HSH.

(2) New approaches to meet this need were indicated:

a) Shortage of professional teachers

b) Association of frustration and failure on the part of the patient with traditional educational methods and consequent lack of interest in adult education

The project immediately posed several questions. In an attempt to meet the educational needs of patients, would it be possible for a psychiatric aide to be freed from his preconceived, rigidly defined custodial role and be allowed to contribute to patient rehabilitation in a new role, that of a program manager in an educational setting? Would it be possible to increase patients' communication skills by this new approach? If so, would it contribute to the patient's total rehabilitation, speeding his reentry into the community and contributing to his successfully remaining there?

Education is typically the crucial variable which determines a person's life style. Lacking the simplest skills in reading, writing, and computation, the undereducated patient finds himself unable to reenter the community as a full-fledged citizen. In addition to the stigma of having been a mental patient, he finds himself walled off from his fellow citizens by a barrier of ignorance, lacking the tools for growth of individual potential to enjoy life.

Increasingly, education is being promoted as a cradle-to-the-grave process uncircumscribed by time and space. Adult basic education is receiving increased emphasis as a partial answer to our nation's many social ills. If basic or continuing education is important for the "normal" citizen, it is doubly important for the mental patient who has been locked out of society for years. With the emphasis in recent years on getting as many patients as possible back into the community, mental hospitals are now faced with the problem of residual, hard-core patients who are multi-losers without job skills, without families, and with little or no education. With these facts in mind, the EDL Learning 100 program was conceived as a demonstration project which would attempt to educate mental patients using a method which was novel and interesting, and which utilized nonprofessionals as teachers.

Method

Subjects. Thirty-one patients were selected by staff on four ward areas of the York-Adams Unit. Each patient's participation was voluntary and, in the opinion of the staff, each was potentially capable of profiting from participation. In the beginning of the experiment, the choice of the participating patient rested largely on the aide's judgment. However, due to the unforeseen rapid movement of participants into and out of the program because of leaves of absence, job placements, etc., referrals to the EDL program later became an issue brought up at team meetings for a decision. A patient was referred to the program largely on the basis of whether it was thought that he could profit from the unique educational approach. Many of those recommended exhibited varying degrees of psychotic symptoms such as withdrawal, delusions, and/or hallucinations. Some of the referrals had participated unsuccessfully in other educational programs at the hospital.

The nonparticipating or control group consisted of 31 patients who participated in various other hospital programs. The mean age of the control group was 46.0 years as compared to the mean age of the demonstration group which was 43.0 years. (Refer to Table 1.) The mean amount of education for the control group was 7.5 years as compared to 7.6 years for the demonstration group. (Refer to Table 2.)

A comparison between the two groups' length of stay is presented in Table 3. The mean length of stay for the demonstration group (13.5 years) is quite similar to that of the control group (13.4 years).

TABLE I

MEAN AGE OF PARTICIPANTS BY AGE AND SEX

Subjects	Number of Students	Mean Age	Age						
			20-29	30-39	40-49	50-59	60-69	Male	Female
L-100	31	43.0	5	7	8	9	2	28	3
Control	31	46.0	3	10	4	8	6	27	4

TABLE II

PARTICIPANTS BY YEARS OF FORMAL SCHOOLING

Subjects	Number of Students	Mean Number Years Completed	Years of Formal Schooling Completed					
			0	1-3	4-6	7-9	10-12	12 +
L-100	31	7.6	1	2	6	16	6	0
Control	31	7.5	0	1	10	12	8	0

TABLE III

LENGTH OF STAY IN HARRISBURG STATE HOSPITAL

Subjects	Number of Students	Mean Length of Stay	Length of Stay (Yrs.)				
			1-5	6-10	11-15	16-20	21-25 +
L-100	31	13.5 yrs.	10	6	4	2	9
Control	31	13.4 yrs.	13	3	3	1	11

Procedure. Initially the demonstration group was divided into three classes, each consisting of approximately ten patients. However, because of the mobility that soon became apparent, the number of class members later varied, settling at about six patients per class.

The three classes were managed by psychiatric aides who were chosen by the nursing staff to be the program managers. Instructions in class procedure were given to the aides in the beginning of the program by an EDL/McGraw-Hill consultant and research staff members. Each aide who served as program manager was known to all of his students because of his continuing role of onward psychiatric aide; therefore, it was felt that rapport was more easily established than in a more traditional classroom setting. Duties of the program manager included: (1) hold regular classes; (2) motivate the student to attend class and to participate; (3) prepare and present lesson; (4) keep attendance and progress records; (5) handle referrals; (6) keep classroom and materials orderly; (7) know proper methods of operating classroom equipment; (8) make arrangements for class trips or projects, etc. The list is not conclusive but serves rather to point out the extra responsibilities taken on by the aides. The extra duties did not in any way relieve the aide of the regular duties for which he was employed.

Each class was scheduled for a one and one-half hour session per day, five days per week. However, this schedule went through many changes before a routine was established. Due to the psychiatric aides' many other preempting duties, classes at first were held irregularly but settled at about four classes per week for each aide.

The students were divided into ability levels on the basis of:

1. The aide's estimation of each patient's ability to learn the materials.

2. Scores on the *Wide Range Achievement Test* (WRAT) and the *Peabody Picture Vocabulary Test* (PPVT).

The educational materials that were used in the project consisted of seven levels of entry from the RA level, roughly equivalent to kindergarten, to the FA level, equivalent to sixth grade adult. Entry levels for the demonstration group were RA, 9 patients; AA, 4 patients; BA, 7 patients; CA, 0 patients; DA, 11 patients; EA, 0 patients; and FA, 0 patients. Students were encouraged to move through the levels at their own pace.

Methods and Instruments of Evaluation. Pretests were administered to the demonstration and the control groups. These tests included the *Peabody Picture Vocabulary Test* (PPVT), and the *Wide Range Achievement Test* (WRAT). The PPVT is designed to provide an estimate of one's ability to understand the correct application of words through the measurement of hearing vocabulary. Since the patient is not required to read, the scale is particularly useful for nonreaders

and for remedial reading cases. Responses may be nonoral, therefore the test has significant advantages for use with certain withdrawn and psychotic persons for whom the tensions of the testing situation may be reduced. The WRAT is used as a measure of achievement in the basic school subjects of reading (word recognition and pronunciation), written spelling, and arithmetic computation. It was designed as an adjunct to tests of intelligence and behavior adjustment.

Pretests were given in August and September 1970, and were re-administered at six- and twelve-month intervals.

The *Test of Adult Basic Education* (TABE) was added to the battery and administered at six- and twelve-month intervals in an attempt to find a more discernible testing instrument for measuring adult achievement in the basic skills of reading, arithmetic, and language. The TABE attempts to measure knowledge indirectly, placing the emphasis on the application of acquired knowledge of terms, facts, and rules.

The *Rehabilitation Progress Profile* (RPP), a behavior rating scale designed to measure a patient's level of functioning, was administered regularly for most patients in the hospital as part of hospital procedure. Scores on this instrument were collected during the sixth and the ninth months.

A satisfactory test of general achievement for a population of the type under consideration seemed not to exist. Therefore, the results of the repeated use of these tests should be cautiously interpreted.

In addition to the objective tests, periodic reports describing class attendance, number of classes held, levels achieved, and additions and terminations to class roster were prepared on a three-month basis, for a total of four reports.

It is important to keep in mind that the demonstration had multiple goals, only one of which was improvement of reading. The demonstration also must be considered as "educational therapy" which may improve the patient's contacts with others and help him to live a fuller life – ideally, outside the hospital. For these goals, certain types of qualitative information have been obtained. Subjective evaluation of the program was achieved by interviews with various people on the wards, some of whom were connected with the program directly or indirectly, others who were aware of the program but not involved with it.

Finally, case studies of five patient-students were written by a summer student working with the EDL program in an effort to chart some of the individual changes taking place.

Results

No significant improvement in reading, arithmetic, or spelling was shown by either the demonstration group or the control group. The scores remained relatively stable for both groups during the three testing periods for all tests. The WRAT means (Table 4) showed very little change, the largest being in arithmetic for the demonstration group (3.9 – 4.9), improving one grade level. The mean IQ score (PPVT) for the demonstration group (Table 5) rose two points (78.0 – 80.0) over the three testing periods while the mean for the control group rose one point (71.0 – 72.0). The TABE means showed almost complete stability in both reading and arithmetic (Table 6).

TABLE IV

MEAN GRADE LEVELS ON WIDE-RANGE ACHIEVEMENT TEST

Group	Number of Students	September 1970	January 1971	July 1971
L-100				
Reading	17	7.3	7.1	7.3
Spelling	15	5.2	5.5	5.8
Arithmetic	17	3.9	3.9	4.9
Control				
Reading	15	5.4	5.6	5.6
Spelling	17	5.5	4.3	5.5
Arithmetic	16	2.9	2.9	2.3

TABLE V

MEAN MENTAL AGE AND IQ ON PEABODY PICTURE VOCABULARY TEST

Group	Number of Students	September 1970	January 1971	July 1971
L-100				
MA	17	12-5	13-2	12-10
IQ		78	82	80
Control				
MA	19	11-0	11-4	11-0
IQ		71	74	72

TABLE VI

MEAN GRADE LEVELS ON TEST OF ADULT BASIC EDUCATION

Group	Number of Students	January 1971	July 1971
L-100			
Reading	15	3.2	3.4
Arithmetic	15	3.8	3.8
Control			
Reading	14	2.7	2.7
Arithmetic	13	3.4	3.4

The RPP is an experimental on-ward behavior rating scale used at the Harrisburg State Hospital to assess patients' functional levels and measurable behavioral changes. It was expected that the therapeutic benefits of the EDL program would bring about improved ward-functioning as seen by staff who do the ratings. Therefore, the mean RPP scores of the demonstration and the control groups were compared with each other as well as with the mean unit score. Very slight variability between groups over the two rating periods in March and June 1971 was shown. As with

the test scores, some improvement was noted on an individual basis.

TABLE VII

MEAN RAW SCORES ON REHABILITATION PROGRESS PROFILES (RPP)

Group	March 1971	September 1971
L-100	45.6	44.8
Control	39.9	43.3
Total Unit	43.1	42.7

Four quarterly EDL reports were prepared by research staff and distributed to staff on the York-Adams Unit. The reports recorded the number of classes held by each group, as well as attendance and progress made by each student. Movement of patients (additions, terminations, and reasons for terminations) was recorded. Meetings were held with ward staff to discuss the quarterly reports. Table 8 shows the total number of classes held by the three program managers. Table 9 shows the changes in the class roster.

TABLE VIII

CLASSES HELD BY QUARTER

Quarter	Classes
1 (October – December 1970)	81
2 (January – March 1971)	160
3 (April – June 1971)	119
4 (July – September 1971)	111

TABLE IX

CHANGES IN CLASS ROSTER BY QUARTER

Quarter	Dropouts	Additions	LOA*	Approximate No. in Classes
1 (October – December 1970)	2	0	2	30
2 (January – March 1971)	10	5	6	16
3 (April – June 1971)	0	3	2	18
4 (July – September 1971)	5	7	3	17
Total	17	15	13	

*Leave of Absence

Of the 31 original class members, only nine remained at the end of one year. Those who were dropped were dropped for a variety of reasons such as job placement, conflict with other hospital

programs, disabling psychoses, or disinterest in the program. Those who were added were referred to class by a number of sources such as doctors, aides who "wanted to see the patient doing something besides sitting on the ward," multi-disciplinary teams, or the patient himself. (Several of the patients heard from other patients about the class and asked to be admitted to it.)

A comparison between the L-100 group and the control group showed that 13 L-100 students went on leaves of absence during the year, while only 6 of the control group received LOA for the same period. Although this comparison seemed to show a trend toward more LOA for the L-100 group, statistically the difference was not significant.

The EDL/McGraw-Hill materials, set up in cycles (30 to each level), required two and one-half hours for a "normal" student to complete. With the L-100 group the rate was 4.6 hours per cycle. However, the average number of cycles completed (based on the remaining original members) in the year of operation was 44, well over the 30 required for one grade level. The average number of hours spent in the program was 91.6 per patient per year (range 8-273).

A questionnaire was administered to eleven staff members connected directly or indirectly with the EDL project.[2] Analysis of the response was as follows:

Ten out of eleven interviewees felt that L-100 was a good program, particularly for getting the patient away from the usual ward routine. This type of program was seen as serving various purposes such as resocialization, remotivation, stimulation, confidence building, basic academic preparation for further education, preparation for job procurement or hospital discharge. One respondent felt that the information should be used as a basis for a total treatment plan.

Respondents saw the program specifically affecting the ward in a number of ways: the patients seemed to be more cooperative and aware of their surroundings; some patients seemed to interact more with other patients; the patients had something to do. Some staff members felt the program had specifically helped the teacher-aide in his work role. The comment on one ward was that the patients looked forward to the class.

About 50 percent of those interviewed knew how patients were chosen for the program and how additions to the program were made. Most respondents felt that with more coordination the program should be extended and should be continued.

Discussion

Testing over an extended period of time, such as was attempted for the EDL project, created many difficulties. The foremost problem seemed to be to find a reliable testing instrument for a mental hospital population engaged in educational efforts. Each instrument, the PPVT, the WRAT, and the TABE, was designed for use with a normal population and therefore may not have taken into account the vicissitudes of mental illness. Additionally, although patients have the right to refuse to take tests and some did, most of them apathetically acquiesced when approached for test taking. One could assume that the motivational aspect would have a bearing on the effect.

It was hoped that the *Rehabilitation Progress Profile* (RPP) would measure the changes that seemed to be occurring with the L-100 group regarding on-ward behavior. Since the RPP scores showed no significant difference between groups, one may assume that there were no changes, or due to the experimental status of the RPP, the changes were not adequately recorded, or group variability canceled out the individual differences.

One of the unforeseen events of the project was the unstable class structure. The constant moving into and out of the program created record-keeping and testing problems and forced the manager-aides into flexibility before becoming comfortable with the procedure as they learned it. Of course, flexibility has its benefits and in this case seemed to have contributed to the uniqueness and certainly to the continuity of the program.

The most meaningful quantitative data resulted from the quarterly reports which were prepared as a method of keeping track of what happened to the individual patients. From this record it was possible to tell just where in the program any patient was at any particular time. On this basis it was possible to pick out individual patients who were showing commendable progress.

The questions answered on the staff-reactions questionnaire indicated that progress was made in the integration of the EDL program into the total treatment plan. For example, the choice of participants in the beginning was somewhat arbitrary but later became a systematic matter of team referrals.

Early in the program, the problem of substitute teachers became apparent and never was resolved satisfactorily for several reasons: the number of aides who could be spared from their expected duties was limited, and aides who were interested in managing the program even on a substitute basis were limited. Therefore, classes never attained the regularity of a "normal" school setting.

The Future of EDL

For the first year the EDL project was monitored by the research staff. It began as a research project sponsored by the nursing staff, but evolved into a full-fledged ward program. Over the past year many people – patients, staff, and volunteers – contributed to making it a viable program.

As it moves from being a research project to an on-ward program, characteristic changes are becoming apparent that will reflect ward needs more closely. A proposal for the future of EDL on the York-Adams Unit has been prepared by one of the program managers and presented to the Unit Director who plans to carry it through. If the proposal is successful, the unit may well program the education of all its patients at the level which is appropriate to the individual, from orientation – for time, place, and person – to college preparatory work.

The EDL program has met the needs of some of those patients who, for various reasons, did not or could not participate in the regular hospital education classes. By holding the classes on the ward, patients who would otherwise find it difficult to attend could participate. In many cases, patients lack the necessary skills to leave the ward and "compete" in a strange setting.

That the patients are proud of their classes can be seen by the following comments of some of the students:

"My class is something to be proud of – from the teacher to the students."

"The class is helping me read better and understand what I read."

"The subjects are very interesting. I like the books they have."

"I think this class will help me to get a good job when I get out of here and help me to understand more about life."

"I enjoy coming here. It is a refresher and, since I didn't graduate from school, it is very helpful."

Many Harrisburg State Hospital patients' deficiencies in reading and arithmetic are significant in that they are critical to their ability to function satisfactorily in the community. Such deficiencies may be the result of (1) never having learned to read or write, or (2) having forgotten previous skills due to illness or prolonged hospitalization. It also has been felt that improvement in either of the aforementioned conditions would likely result in improvement in other areas. Therefore, the objectives of the EDL program were: (1) basic education, (2) relearning or reviewing, and (3) remotivation. However, to state these objectives is not to preclude others such as resocialization, increased self-acceptance, and self-confidence, for example.

The future of EDL would necessarily include its integration into the total treatment program. In working with the mentally ill, a differentiation is sometimes mistakenly made between education and therapy. If the the EDL program helped the patient in his adjustment to his environment, it was therapeutic.

Lastly, the future of the EDL program could realize the more effective use of nonprofessionals in a rehabilitation role. A Texas State Hospital project[3] which utilized attendants as teachers for adult education courses was so successful that the hospital now considers teaching a regular part of the attendant's work. In the EDL project, the importance of the psychiatric aide was the subject of a paper, "The Development of the Psychiatric Aide as Program Manager,"[4] which emphasized the importance of the aide's natural role in the patient's environment. The future of the program is dependent upon the realization that psychiatric aides have much to contribute to the total treatment program as demonstrated by this project.

References

1. Matter, Betty, "Educational Developmental Laboratories." Harrisburg State Hospital Research and Projects Committee Monthly Bulletin.Vol. II, no. 3. pp. 37-38.

2. Matter, B., and Fried, P., "Staff Reaction to the EDL Program." Harrisburg State Hospital Technical Report, No. 71-49.

3. Harrison, P., Davis, H., and Von Rosenberg, R. (Big Spring State Hospital, Texas), "Aides Teach Adult Education Courses." *Hospital and Community Psychiatry*. 1968. 19(6). pp. 176-177.

4. Matter, Betty, "The Development of the Psychiatric Aide as Program Manager." Harrisburg State Hospital Technical Report, No. 71-51.

Case Studies of EDL Students

Priscilla Fries

Robert

Not long ago, Robert was a "backward patient," thought to be so regressed that his meals were brought to him. He was treated as a very low-functioning patient. Then, a staff member took an interest in him and there was a glimmer of improvement.

Robert, who is approaching sixty, graduated from a rural high school and worked as a truck driver until he became ill some thirty years ago. He has been hospitalized at Harrisburg continuously for most of that time. Robert was diagnosed as paranoid schizophrenic with hallucinations and delusions. Long-term institutionalization may have had a grossly adverse effect on him for he has maintained his delusional system over all of these years.

His progress is best summarized by his teacher, the psychiatric aide, who writes:

"Robert's participation in the class, overall, is good. He retains a prolonged attention span, and is able to function in all areas with a minimum of supervision. His attendance is excellent, and he has never refused attendance.

"Robert began the EDL program on the RA level. At that time (September 1970), he did not have the personal organization, perceptual and/or visual efficiency, orientation to time, place, and person that were necessary to promote productive interaction and communication in the classroom. The reasons for this behavior are clear. For a period of years he had no close interpersonal contact with any external stimulus, human or associative. The hospital provided for his basic needs but, due to the lack of productive programming and the trend towards group activities, he was forgotten as an individual.

"His behavior could be described as unrealistic, psychotic, or passive-dependent. He was unable to respond to such simple directions as writing his name. If he needed a pencil, he would not ask for one but would wait until it was provided. He stated the year as 1984; did not know the date or the day of the week. In class discussions his conversations were not directed toward the issues involved. On the ward he was quite seclusive. At one time his meals were carried to him from the kitchen. His personal hygiene was poor; the aide had to insist that he take a shower. He had no friends and communicated (usually unrealistically) only when encouraged to do so.

"Since the beginning of class to date, Robert has shown both a consistent and progressive trend toward improvement. He can use all of the instructional instruments with an estimated comprehension average of 60-70%. The RA level gave him a good background for organization, and his progress might be attributed to this.

"His best work is done with the Aud-X, Tach-X, and Study Skills Library (SSL). With these the patient is able to hear, see, interpret, and check responses. This is important for him in order to condition and ensure consistent continuity in making realistic decisions.

"Working with the Controlled Reader is more difficult for him. Comprehension of material is low (40-50%), but gradually improving. Many other factors enter into this: eyesight,

age, reflexes, mental condition, etc. At the AA level, he was reading less than 90 w.p.m. with 50-70% comprehension progress, which is slow but still consistent.

"The *GO* material presents a different kind of problem. It is independent without checks and balances. Supervision is needed in some areas in order to promote responses that are consistent with the identification of concepts presented previously in the cycle.

"Surprisingly, the SSL is within acceptable standards. This could be because of the difference in the type of material presented.

"Robert has shown considerable improvement on the ward. He eats his meals in the dining area, gets his own tray, and disposes of it. He takes showers regularly, and dresses and grooms himself. He has been observed interacting with other patients and even smoking cigarettes. He knows the year, but is not yet consistent with the month and day, although he is now more oriented than he ever was before. He also knows the name of the hospital, which he didn't know previously.

"As for the EDL program, it stresses making correct, realistic choices, and this may be contributing to his improvement in time and space orientation. His level of placement (CA) makes this neither too easy, nor too frustrating. The objective is to have the student think, respond, and interact in a structured, progressive manner, in order to promote accepted behavior and independence."

Betty

Graduating from an urban high school with honors, and unable to continue her education due to lack of finances, Betty became office manager for a private hospital. She was a housewife, mother, Sunday School teacher, president of the PTA, and active in civic affairs.

With the death of her father, and the additional burden of her husband's illness, Betty started drinking excessively, and continued to do so for the next twenty years. Her illness manifested itself in a loss of memory for recent and remote events, with periods of irrelevancy and incoherency. When she was hospitalized two years ago, Betty was diagnosed as suffering from chronic brain deterioration which affected her memory and orientation. She since has improved physically and much of her illness has reversed itself, but she continues to behave compulsively. This is most evident in her continuous begging for cigarettes.

During her stay at the Harrisburg State Hospital, Betty attended only one education program – the EDL project. Her physician hoped that participation in the program would help prevent further regression. She began attending class in the spring of 1971 at the DA level and, when she was discharged four months later, she had reached the EA level of *Learning 100*. Though Betty went to class willingly, she often forgot to attend. Many mornings it was necessary to search the ward for her and remind her to go to class. Loss of memory hindered her learning ability and her participation in class – she could not answer questions about reading material after any length of time, nor could she grasp the techniques of operating the classroom instruments.

Apparently she had retained school knowledge very well, for she was consistently accurate when completing workbook material, and scored relatively high on a verbal IQ test and achievement test. According to Betty, participation in the EDL program refreshed her memory and helped her more than any other activity during her hospitalization.

She became more cooperative while participating in the project. Whereas she had previously ignored reprimands and suggestions (especially in the areas of hygiene), she will now bathe, dress, and comb her hair when told. Betty continued to improve, her progress was reviewed by the staff, and she was discharged from the hospital into a supervised setting.

Charles

Charles, age fifty-three, has been a resident at the Harrisburg State Hospital for thirty years. Charles's family needed his help and he left school to work following completion of the eighth grade. Apparently he was an average student academically. Citing instances of getting into fights and being suspended, Charles says he liked school, but they didn't like him.

Quite seclusive, Charles generally does not associate with any other patients. He does not hallucinate, nor is he delusional. In 1969, Charles was assigned to the hospital education program, but he would not attend. In the past, he had been given work assignments, but he had failed to assume the responsibility of attending; *he now willingly attends the EDL program.* He likes the class because it helps him to get away from the ward.

Entering the EDL program at the BA-1 level, Charles has been progressing slowly but surely during the past ten months. He is now at the BA-27 level. The standardized tests used in evaluating the project are further proof of Charles's improvement: he gained twenty-seven points on an intelligence test after ten months, and improved almost an entire grade level on an adult basic education achievement test.

Commenting on Charles's participation in class, his teacher writes: "Charles is a very quiet, extremely cooperative student, but lacks certain skills necessary for independent life. His primary difficulty is in verbalizing his experiences, in putting his thoughts into words. This is most apparent in his inability to relate what he has just heard in a story, for example.

"Charles contributes freely and meaningfully to class discussions but in a very low-key, modified way. If left alone, he might not communicate at all. Class community, however, keeps his mind active, even if it is in this emotionless, low-key fashion. Charles gets along very well with the other class members, has a good attitude, works hard, and wants to progress. In a manner suited to his quiet personality, he definitely has."

Charles left the hospital to enter a supervised setting in mid-1971.

Helen

"The only thing I like now is going to class," says Helen, a patient in her mid-forties. Helen is a quiet woman who has been hospitalized periodically for the past twenty years. She has been at the Harrisburg State Hospital for three years.

Helen attended an urban high school and graduated third in her class. She enjoyed her school work and was encouraged to do well by her parents. Popular with her schoolmates, Helen joined school activities and was voted class president several times. She attended business school for one year but did not pursue that line of work; instead, she worked in her father's jewelry shop. Since her illness, she has not worked.

Helen's illness manifested itself in a feeling of depression, a vague delusional system, and social introversion. She would rarely socialize with others and even stated that she knew others were concerned for her, but she had no real concern for anyone else. Prior to the EDL program, Helen had not attended any hospital education programs. She has always been cooperative and helpful on the ward.

Helen says that she sometimes has trouble motivating herself to go to class but, once there, she really enjoys it. In fact, one day Helen was unusually upset and the staff thought that she was too ill to attend class; five minutes after class had begun, however, she appeared, saying that she thought she would feel better in class. Generally, Helen's attendance in the EDL program has been excellent. She began the program in the fall of 1970 at the DA-1 level and she has progressed to EA-9. As one of the better students in her class, Helen completes her work accurately and thoroughly, and operates the Aud-X and Controlled Reader independently. Her teacher often comments about her helpfulness in assisting with classroom activities.

Though Helen's personal hygiene and appearance have not really improved, her charge nurse has commented that Helen's social interaction on the ward has increased. She now verbalizes her feelings and is in better contact at times.

Her caseworker has reported that, in the past year, Helen has become more accepting of herself and has expressed more concern for others. She is visited frequently by relatives and she enjoys leaving the hospital on short-term leave. Though her chances for discharge still look dim, they will improve if she continues to develop. The EDL program is reacquainting her with the social environment from which she has been absent so long. When asked for her opinion on the EDL program, Helen commented, "It helps you remember. I can understand better."

June

When June was first admitted to the Harrisburg State Hospital, the following was written of her: "This girl is an inadequate person of the underprivileged class who has had a limited education and intellectual background. There has been a definite personality change over the past two years and a gradual social withdrawal." It was also noted at the time that her school knowledge was fairly well retained, though her memory was impaired and she exhibited a short attention span and possible defective mental development.

Quitting school at the minimum legal age, June completed only the second grade. She worked as a domestic until she became ill twenty-five years ago. Except for a brief parole, she has remained hospitalized at Harrisburg during the entire period, with very few visits from friends or relatives. She is quiet and introverted on the ward, but helps with housecleaning chores. The staff reports that she does not hallucinate, nor is she delusional, maintaining pretty good contact. She has been considered for discharge to a supervised setting, but she maintains dependency on the hospital and fears leaving.

Though June is one of the slower patients in class, she has made gradual but consistent progress moving from AA-1 to BA-9. After she completed the AA level, her teacher thought she was ready to try CA material, but this proved too difficult for her and she dropped back to BA-1. She is learning to operate the Aud-X instrument independently and is not afraid to ask questions when puzzled. Because she has had such a poor educational background, June is learning reading and communication skills that are quite unfamiliar to her.

According to the staff, she has become more responsive and sociable on the ward, and is taking more interest in her personal appearance – she recently got her hair done for the first time since she's been at the hospital. Perhaps with continued progress in the EDL program, June will gain the confidence and independence necessary for discharge and social adjustment outside the hospital.

Anecdotal Comments

(Based on a paper prepared by volunteer Joe Thomas.)

William

William is a tall, slender young man who has been a resident at the hospital for twelve years. Anyone who knows him would agree that he is a quiet fellow who tries to avoid company whenever he can. Before the EDL program, he had been extremely uncommunicative and spoke only when spoken to, usually in monosyllables. Since his participation in the EDL program, and with the additional help of a college student who volunteered to tutor him, William has shown some improvement.

On one of the volunteer's visits, William was actually waiting outside the recreation room for him. Since his previous characteristic behavior had always been to avoid any social contact, this example is a strong indication that his social skills are indeed improving. Also, at the end of one session, the volunteer asked William if it would be all right for him to come back again. William's answer of "You don't *have* to" again indicates a step in the right direction – he didn't flatly refuse an offer of company.

To paraphrase the volunteer in still another example: ". . . we played Scrabble, the only educational game I could think of. His ability with words was surprising; not only the more difficult words that I made, but also his ability to make up words. I remember this week specifically for two reasons. First, because he asked me if I was coming back on Wednesday and, secondly, because it was the first time I had heard him laugh. We were doing a puzzle and, when we finished and he recognized the character, he quite startlingly exclaimed, 'Mickey Mouse!' and began to laugh."

About John

Another volunteer related an incident about the patient with whom she had been working. John had been described by one of the staff as an isolate – "He only speaks when spoken to." But this did not seem to be the case; actually, this patient was quite friendly and greeted other patients when walking around the grounds. Also, several months after the volunteer stopped her visits with John (but still visited the hospital), he would initiate conversation, asking her about herself and college. The staff member's comments about the patient (which contradicted the facts) were probably a reflection of his behavior prior to his participation in the EDL program, when John was what one might call a helpless "vegetable." As a result of the program, he became a person again and is now quite active and functioning. In fact, he was recently seen sitting in the smoking room conversing with another patient. This is indeed an improvement in John's social life – as the aide in charge of him commented, "That's the first time I've seen John talk with another patient."

Another

Not only have social skills improved among the patients, but good grooming habits have as well. For example, one patient who habitually exhibited a sloven and unkempt appearance has taken more interest in his dress and grooming (he now looks clean and presentable). Even his doctor noticed this improvement in the patient. Another patient elects to wear his Sunday-best white shirt and tie during his tutoring session. By choosing to look his best for his teacher, this patient is showing marked progress in his grooming and social habits.

And Another

After one testing session in which a young control patient demonstrated minimal reading ability, the tester discussed this problem with the patient. Though the patient had been attending the regular education class, he felt that he was not learning enough and said he wanted to go to Tony's school – the EDL program. It seems that the progress of the L-100 students was becoming apparent on the wards, and the enthusiasm for it was spreading to other patients.

Addendum

Two of the chronic patients had been at the hospital more than twenty-five years. Throughout all those years, their names had been mispronounced by members of the staff. Through their participation in the EDL program, these discrepancies have been corrected.

A summer worker with a rather difficult name (Priscilla) was introduced to the students at one class session. Since that time, one patient-student greets her by name each time he sees her – a good indication that social skills are improving.

The Development of the Psychiatric Aide As Program Manager Harrisburg State Hospital Technical Report No. 71-51

Betty R. Matter

According to a survey done by the Council of State Governments (1969), the most outstanding problem facing agencies such as mental hospitals is the shortage of personnel and the need for overcoming this barrier to implementation of demanding programs. The inadequate number of mental health professionals available, and the rigid clinging to methods no longer appropriate to needs, *forces* ways of finding and using untapped sources of manpower or using existing personnel to a greater advantage. However, according to Nicholas Hobbs (Guerney, 1969), we should not train ourselves to do better what we are already doing. Bold and innovative approaches for providing mental health services are required, including such overlapping domains as education, welfare, housing, and other human services.

An observable trend in mental health care today is the blurring of disciplinary responsibilities, resulting in role diffusion. For example, the role of the psychiatric ward aide is being altered, moving toward more responsibility in therapeutic programs developed for the mental patient. The traditional role of the aide is that of a custodian and care giver, centering around basic nursing skills. The aide is the bottom rung of a hierarchical ladder, yet he spends comparatively more hours of his working day with the patient than any other hospital worker, regardless of level. He sees the patient's mood changes, learns his wants and desires, and becomes a trusted friend in whom the patient confides. The aide is the first to see how a patient reacts to changes in medicine or treatment for example, yet traditionally, he has little responsibility in recommending courses or changes of treatment.

With many mental patients, physical care is not a paramount responsibility; therefore, the traditional custodial or nursing care rendered by the psychiatric aide is not enough. The challenge of changing concepts in approaches to treatment clearly indicates the more efficient use of existing personnel, particularly the aide.

Guerney (1969) suggests that in certain instances nonprofessionals seem to provide therapeutic effectiveness beyond that accomplished by the professional. The psychiatric aide, by virtue of his natural role in the patient's environment, becomes a "naturally significant other" to the one being helped, and as such is in a favorable position to be a change agent. The question is not whether it is appropriate for aides to influence the patients (it is being done), but whether ways can be found to put this influence to good use. If the interaction between the aide and patient is properly structured, the results may have ramifications which help to bridge the cultural gap that often exists between the professional and the person he wishes to help. Being from the same cultural environment as the patient, in many cases, the aide in the helper role can provide many benefits to the patient directly. In addition, he can supply many valuable suggestions and interpretations which the professional should consider when he formulates policies and procedures affecting the patients.

A research project was begun in September 1970, in the York-Adams Unit of the Harrisburg State Hospital, in which psychiatric aides serve as managers of a program of individualized instruction, based indirectly on operant conditioning techniques. The project involves a new approach to training in communication skills, which was designed to stimulate and hold the interest of adults. A survey of the hospital population showed that over half of the patients had an eighth-grade education or less. Assuming that lack of education contributes to the overall mental problem and the problem of getting along in the community, the project was conceived with the hope that communication skills such as reading, writing, and listening could be improved. The classes are held five days per week, one and one-half hours per day, on a ward where provisions for professional teachers are nonexistent.

The program is based on programmed learning methods involving the use of teaching machines and appropriate workbooks. The aide is not required to teach, since all the right answers are contained in the materials. The psychiatric aide's role is that of a manager of a learning environment.

The results of such a program depend on a variety of factors, some of which are presented in detail.

1. Planning and Training

   Pre-job training began approximately six weeks before classes began and started with a one-day orientation to materials and equipment by company representatives. Thereafter, training was of a support type, one-to-one, explore-together relationship of medical research technician and psychiatric aide. The core of the training was the lesson plan and once it was mastered, the aide was ready to start. The aide learned by doing; he had to adapt and improvise because neither the setting nor the population was "normal." The aide reported that after about a month of holding classes, he began to feel comfortable in the classroom situation.

   In order to avoid anxiety as much as possible, the psychiatric aides were included in the step-by-step planning for the program. Finding a suitable, unused room on the ward was a problem. In retrospect, more thought should have been given to this task. The present room is too warm, too small, and too inaccessible for the amount of use, and may have to be changed. Desks had to be found, shelves had to be built. Patients had to be tested and selected. Those participating were selected entirely by the aide and the other members of the ward staff, the MRTs supplying only the testing results.

2. Support

   Support of the aide came in many forms and from many directions. Support from the immediate trainer, the medical research technician, was not diminished for several months, and then only very gradually as the aide became more secure and self-reliant. It must be remembered that the aide's duties as program manager were in addition to his regular job as psychiatric aide, the job for which he was hired. Setting time apart for him to manage the education program had to receive sanction from his supervisors and had to be understood by his co-workers. Without support from these directions, the aide could not succeed. The atmosphere on the ward had to be one of cooperation and nothing less than total commitment in order for the program to function efficiently.

   It would be unrealistic to believe that this commitment was born overnight – many problems had to be worked out. I shall relate just one example. Since Harrisburg State Hospital is an open hospital, the patients are more or less free to come and go as they please. Not being used to the schedule of classes, patient-students often were

not on the ward or to be found at class time. It took some time for ward personnel to realize that it was their responsibility as well as the manager-aide's to remind patients to attend class. Initially, much class time was wasted gathering the patients for class.

Being a demonstration project, the classes received many visitors. This was a source of ego-support for the teacher, but became a threat to the patient-students and had to be restricted. Restriction came at the request of the psychiatric aide, whose sensitivity to the feelings of his students made this his primary concern.

Support for the aide came from an unexpected direction. At least one aide reported that her students gave her confidence in the classroom. She could count on several of them to help out in general, or help the slower learners or those with specific problems. In at least this one classroom, the age-old therapeutic approach of using a person with a problem to help another who has the same problem in a more severe form was effected. Often, the helper profits as much as the person receiving help, and the benefits that accrue to the psychiatric aide in his role may also accrue to the patient in a helper role.

3. Size of Class, Attendance, and Regularity

Three classes of ten patient-students were formed, each scheduled for one and one-half hours per day. It soon became apparent that the educational deficiencies of the patients were too individualized for the psychiatric aide to manage ten at a time. With few exceptions, and regardless of previous educational level, the patients were not capable of working independently. Some patients who required constant attention had to be dropped. Efforts to secure extra help for the aide resulted in sporadic help of volunteers and college students.

I do not want to minimize the value of volunteers and students. They are a valuable source of help; however, much time and effort must be spent in order to hold their interest and promote in them a feeling of usefulness. The amount of time (usually a few hours a week) volunteers and students can spend limits their effectiveness if it is not planned and coordinated meticulously. The most promising area of *immediate* help seemed to come from a few of the better patients in the class who seemed only to need the opportunity to lend a helping hand.

Classes were scheduled for five days a week corresponding to the aide's work week, which included alternate weekends. In the early stages, regularity of class was not easily accomplished, for various reasons. Many times the supervisor failed to relieve the psychiatric aide of his other ward responsibilities, such as ward coverage or dispensing of medicine at the time of class. There were times when ward activities, such as bus trips or other recreation, were planned which took the students needlessly out of class, for they could have participated in these activities at another time. Nevertheless, such activities were not omitted in favor of class; however, when the aide was advised of such activities in advance, he planned for them with his class. (Some of the most interesting classroom discussions resulted from such trips.)

Generally, attendance suffered most with failure to plan ahead for individual patients' appointments and work assignments. Not only was ward cooperation necessary but, in the case of work assignments in particular, cooperation of other hospital areas and staff had to be solicited. To prevent a tug-of-war with the patient in the middle, the

need for careful planning for the patient and intra-staff communication cannot be minimized.

4. Personal Characteristics of the Aide

Riessman says (Guerney, 1969) that there are many types of nonprofessionals: some are earthy, some tough, some angry, some are surprisingly articulate; some may possess characteristics that interfere and keep them from being effective as change agents, such as indignation and punitiveness, for example. The personal characteristics of the helper and the receiver of help are major factors influencing the process and outcome of the helping relationship. Guerney (1969) sees requirements such as reasonably adequate intellect, patience, interpersonal sensitivity, self-control, and a strong motivation to help others or the potential for developing them.

Kolb and Boyatzis (1970) write of the affiliation motive which indicates that the intimacy required for effective understanding of how the patient (in this case) perceives his problem is natural between aide and patient.

The helper must see himself as capable of giving help but must not feel himself to be the "know it all" expert. The helper must be willing to influence and at the same time have empathy with the feelings of the person he is to help.

Guerney expressed the concern of some that the trained nonprofessional may turn out to be a watered-down carbon copy of the professional who trained him. This seems unlikely if personal characteristics are considered. Hopefully, the acquired specific skills in combination with the psychiatric aide's unique qualities will create therapeutic effectiveness beyond that which would be achieved by professionals. As reported by Kolb and Boyatzis (1970), Prakash found that ineffective change agents were more concerned with their own personal goals and with their political position within the organization than with task accomplishment.

In training the psychiatric aides for this particular program, several factors stand out: (1) Even with constant elbow support, one aide had to be replaced. (2) Each class developed its own personality because of the unique interaction of aide and patients. (3) Aides trained for relief when the regular aide was on vacation worked out best if they came from the same ward area as the regular aide and his patient-students. (The "naturally significant others" seemed to be in effect here.)

5. A Well-Defined Program

Riessman points out (Guerney, 1969) some of the dangers of using the trained nonprofessional: (1) the newness of the programs, (2) the vagueness of the many goals, (3) the tasks only beginning to be defined, (4) competitive feelings between personnel, (5) great gaps in their knowledge and know-how. While the aides in this project are certainly learning as they go, the basic structure and goals are well defined. Lesson plans are the base of operation for the aides, but they are encouraged to make modifications to suit the needs of their classes. The goal is to increase patients' communication skills but it is expected that many other therapeutic benefits will accrue. Any competitive feeling between the psychiatric aide and other members of the ward staff, professional or nonprofessional, can hopefully be put to constructive use. By having regular meetings of all the program managers where information may be exchanged, peer learning should result. These meetings were found to be extremely important for learning from each other. In addition to information exchange, problems can be aired and per-

haps solved by sharing a similar experience. The professional would be wise to use the information the aide can provide in overall planning and individual consultations.

6. Patient-Aide Relationship

Guerney speaks of a duality in this type of relationship and indicates that the attempt of the psychiatric aide to change the patient will almost inevitably result in the helper himself being changed for the better as a consequence of his efforts (p. 247). The same principle applies to a teacher who says he learns most when he teaches. Hadley, True, and Kepes (1970) report from the Purdue Study the following therapeutic effects of the preprofessional on the patient:

(a) He talks with the patient about real life issues.
(b) He appears to treat patients like people.
(c) He is sensitive to the feelings of the patients.
(d) He appears to recognize the effect he has on the patient.

In our project, the program managers have referred their patient-students for eye examinations, consultations with social workers, and speech and hearing examinations. They have recommended the most needy, in their opinion, for one-to-one tutoring help with volunteers and college students. They have taken their students to the toggery to be outfitted because they wanted their students to look "nice" for trips. Program managers have added patients to their classes because they "want to get them doing something besides sitting on the ward." One program manager is anxious to start a behavior modification program for two of his students so they can get off the locked ward where they've been for years.

What are some of the benefits besides the avowed goals-increased communication skills in patients-that accrue from such a project? The development of psychiatric aides as program managers should result in a new concept of patient care. But in addition to the direct benefit of the patient, which could be the subject of another paper, those benefits derived by the psychiatric aide are advantageous not only to himself and to the patient, but to his family and the community as well.

According to Riessman (Guerney, 1969), such development should result in new leadership which may carry over to the community and an improved self-image which results from doing something worthwhile. In planning for his class, the program manager will have opportunities for community contact, and may become a spokesman for mental health in his community. Commitment to such a task should result in concern or a stake in the system, and new status and prestige dimensions.

Such a project should point out the necessity of program planning across disciplines. The planning and cooperation involved should hasten the breakdown of professional suspicion and jealousy and promote cooperation and openness which place the clients' needs in the foreground where they belong. The project should show that, given the opportunity, the psychiatric aide can meet the challenge of more responsibility and participation in certain aspects of decision-making. An area of serious concern remains to be solved, however. In the present job classification system, the aide has little opportunity for advancement. In order to compensate him for his added responsibilities and training, career lines must be established so that the nonprofessional also can move up the ladder.

References

Guerney, Bernard G., Jr. (ed.), *Psycho-Therapeutic Agents: New Roles for Nonprofessionals, Parents, and Teachers.* New York: Holt, Rinehart and Winston, Inc. 1969.

Hadley, John M., Ph.D., True, John E., Ph.D., and Kepes, Sherwin Y., Ph.D., "An experiment in the education of the preprofessional mental health worker: The Purdue Program." *Community Mental Health Journal,* No. 1, 1970. Vol. 6. pp. 40-50.

Hobbs, Nicholas, "Mental Health's Third Revolution." In Bernard G. Guerney, Jr., *Psycho-Therapeutic Agents: New Roles for Nonprofessionals, Parents, and Teachers.* New York: Holt, Rinehart and Winston, Inc. 1969. pp. 14-27.

Kolb, David A., and Boyatzis, Richard E., "On the dynamics of the helping relationships." *The Journal of Applied Behavioral Science,* No. 3, 1970. Vol. 6. pp. 267-289.

Riessman, Frank, "The 'Helper' Therapy Principle." In Bernard G. Guerney, Jr., *Psycho-Therapeutic Agents: New Roles for Nonprofessionals, Parents, and Teachers.* New York: Holt, Rinehart and Winston, Inc. 1969. pp. 87-95.

The Council of State Governments, *State Mental Health Programs and Personnel Administration.* Lexington, Kentucky 40405. 1969.